

Community Health Worker Programs Qualitative Study: Summary and Detailed findings.

This section of our study involved identifying leaders and experts on community health worker (CHW)-based perinatal programs that serve the overlapping populations of rural and African American women and babies, and conducting detailed telephone interviews with ten of these informants. We aimed to learn about existing models that involve CHWs in perinatal health with these two populations, better understand how CHWs generally fit into perinatal health care, and gain insights into how they might be better utilized to address infant mortality in Maryland.

The study was exploratory and limited in scope. Its aims therefore did not include: a) obtaining a full inventory of how many CHWs are involved in perinatal health care in Maryland and in what capacities/relationships to nurses and physicians; 2) investigating the evidence base for the efficacy of CHW-involved programs in improving birth outcomes; or 3) fully exploring mechanisms for payment/reimbursement of CHWs within MCOs and other health care providers; The first two of these aims were somewhat covered by the inventory/survey and literature review components of our larger study. The third is a complex issue being taken up by a separate government working group on CHWs, and is beyond the scope of this study.

In this appendix, we explain our procedures, summarize our key findings, then provide an in-depth overview of the findings that includes examples of key programs and the actual quotes from which the key findings are drawn, sorted by topic.

I. Procedures

The study protocol for this sub-study was approved by the University of Maryland Institutional Review Board April 17, 2019. The protocol involved an overview of the study, a written consent form for all interviewees, a semi-structured interview questionnaire with a list of specific questions, and an email & phone protocol for recruitment of participants.

We identified potential interviewees for this study through publications on community health worker-based perinatal programs that we had found in the literature review, and through referrals from experts

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we consulted in rural and urban perinatal health programming. These experts included Jenifer Fahey, a Baltimore-based midwife and faculty member at UMB; as well as rural and urban health experts involved in the MHCC work group; and contacts the investigators had made at national research meetings/conferences on perinatal health. We made a list of potential interviewees from these sources, then contacted all of these potential interviewees via email and telephone follow up. Some of our initial contacts from this list identified alternative or additional contacts for interviews (snowball sampling).

Through this method, we identified 21 potential interviewees, and secured participation of ten. These interviewees included the following mix: three experts on rural community health worker programs, one of which served pregnant women exclusively, one expert on urban community health worker programs serving African Americans; two Healthy Start experts/leaders – one serving rural + African American populations and one serving urban African American populations; one expert on B'more for Healthy Babies, an urban perinatal program that utilizes community health workers and targets a predominantly African American population; one expert on MCOs' use of community health workers in perinatal programs; one expert on Doulas in urban African American communities; and one expert on community birth centers in urban African American communities. This group represented an almost even mix of rural and urban experience, as well as a wide variety of programmatic experience. Seven out of ten had worked in Maryland: three had been involved with out of state programs; and one had worked both in Maryland and another state.

After a person agreed to be interviewed, we sent them the consent form and set a date for the interview with them. Before each interview, we obtained the written consent form, then reviewed the consent form with the interviewee over the phone, and requested oral consent to record the interview. All ten of our interviewees signed the consent form and agreed to have the interview recorder. Most interviewees agreed to be identified by name. However, some chose to remain anonymous for the purposes of this publication or requested prior approval for publication of any identified quotes or paraphrased material. After completing the interviews, we had them transcribed. One co-investigator reviewed each transcript and identified key codes and themes, then the investigators met to review the interviews jointly and to reach consensus on the topics, themes, and key findings elicited from the interviews. Below, we discuss our key findings.

II. Key Findings:

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Overall, the interviews underlined that that number of existing models have successfully engaged community health workers (CHWs) or similar workers, such as Doulas, “outreach workers” or “resource parents” in meeting the needs of women during pregnancy and the postnatal period. Our interviewees define CHWs broadly, as people with no professional education (i.e., not a nurse or social worker) but with parenting experience, cultural and community connections to the women in the program, and specific short-term training. While Doulas receive a special type of training and serve a specific function that may not be the same as the CHW, for the purposes of this study we found that these workers belong under the broader umbrella of community-based paraprofessional/non-professional health workers involved in perinatal care. The key distinguishing factor was between the paraprofessionals/CHWs and the professionals including visiting nurses and social workers.

Interviewees shared with us the best practices that have been developed over many decades – what one interviewee characterized as the unique ability of the CHW to meet the mother “where she is [and] where her family is,” and to work with the mother to meet her goals, rather than setting expectations about behavior and adherence to treatment without considering her social and family circumstances or her cultural needs. “CHWs know their communities well/better than outside providers, because they come from the communities they serve,” one interviewee explained. CHWs often go out into the community to recruit pregnant women for the programs in which they serve, sometimes through innovative events such as community baby showers, but also through word of mouth or referral from health care providers. CHWs can be assigned to medical practices. CHWs sometimes visit pregnant women at home, but CHWs should not be confused with nurse home visitors: their primary role is not clinical, and they also visit women at convenient sites in the community, maintain contact through email, text message and phone, and hold support groups for pregnant women. CHWs, the interviewees emphasized, can play a unique and flexible role in serving women at high social and medical risk and their families– not only women with co-occurring health conditions such as diabetes or high blood pressure, but also those who are at risk of poor birth outcomes primarily due to non-medical factors such as poverty, geographic isolation, educational deprivation, intimate partner violence & other family dysfunction, substance abuse, and housing instability. The CHW, by virtue of connections to the community and culture, parenting experience, and relational skills, can gain the trust of the pregnant woman and her family members even in an environment where mistrust of medical professionals is high, and help her navigate pregnancy in a way that professionals are unable to do.

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Our findings indicate, however, that institutional/organizational knowledge about how to effectively use perinatal CHWs has up to this point often stayed within these programs and organizations. To better build upon the existing base of experiential and organizational knowledge, a strong need exists for wider diffusion of this knowledge of best practices & innovative practices/models beyond the walls of particular organizations.

One primary reason that successful programs have not shared their knowledge with others is that few have found sustained funding and have therefore been focused on obtaining the next grant or other fundraising to keep their doors open, rather than on publishing and disseminating their practices. This struggle for sustainability and unmet need for a stable and sufficient source of funding represents another key finding of our interviews.

Some of the experiential/organizational knowledge that our interviewees shared on what CHWs contribute to perinatal health care is summarized in these nine points:

1. CHWS ACT AS HUBS OF CARE COORDINATION: Interviewees emphasized that the CHW or Doula is the linchpin in effective care coordination. This involves assessing the woman's needs and connecting with medical and community resources. "Women need, they need help in navigating the healthcare system and coordinating the care between the different places they need to go, and looking for ways to make it more convenient for them," one interviewee explained. The CHW may work with women who are prescribed 17P – a progestogen shown to reduce repeat preterm birth – to get to their appointments for their weekly injections. In coordinating medical care thus, **the CHWs may reduce the use of the health care system by "high flyers"**- people who have specific, chronic health conditions (including pregnancy complications) who often show up at Emergency Rooms, and thus reduce health care costs.

2. CHWS MONITOR PREGNANCY AND ASSESS HEALTH BETWEEN PRENATAL VISITS. This person maintains contact with the pregnant woman in the all-important times between prenatal visits to do the ongoing monitoring (surveillance) of the pregnancy, and continues in the postpartum. Interviewees emphasized **that training of CHWs and Doulas include recognizing the signs and symptoms of preterm**

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labor as well as being attuned to how pregnant women might express this non-clinically. For example, a woman might say at 28 weeks “I feel my baby balling up,” prompting the CHW to contact the clinician to ensure that the woman receives prompt medical attention, according to one interviewee. **The CHW may conduct basic health assessments**, such as blood pressure screening or home testing for STIs and other health conditions that may affect pregnancy.

3. CHWS ASSESS AND ADDRESS MATERIAL NEEDS THAT AFFECT PERINATAL MEDICAL CARE & HEALTH:

The interviewees emphasized CHWs’ role in assessing and addressing the patient’s larger economic and social needs that affect her during pregnancy and postpartum – especially when programs cannot employ sufficient numbers of social workers. The most important unmet needs mentioned by the interviewees included **housing, transportation, food, and in the postpartum, diapers**. Interviewees stress that the CHWS also play a vital role connecting women to resources including federal and state benefits. One mentioned that **their CHWs use the Benefit Bank, an online resource which provides a single portal though which the clients can apply for all benefits (SNAP, WIC, TANF, etc.)** and also file tax returns or FAFSA and register to vote (<https://selfserve.thebenefitbank.org/ums>). Another pointed to **Aunt Bertha**, [<https://www.auntbertha.com/>] a national website that connects people to local services at free or reduced cost including healthcare, housing, food, job training, transit, legal assistance, household items, and educational resources. “You can use it as a referral source amongst partners. And you can follow individuals all the way through,” explained the interviewee.

Several interviewees emphasized **stable and safe housing is a common unmet need that CHWS help women meet**. Lack of safe and stable housing interferes with women’s ability to obtain adequate prenatal care, as well as compromising their health and that of their newborn. One interviewee in Baltimore explained that her organization’s clients are “living with somebody else this week, and maybe next week they may be living someplace else. Or, they may be in a homeless shelter... And if they have housing in the city, is it lead-free? Is it safe, okay? Does the child have asthma? Is there carpeting? Are there rodents and bugs?” The interviewee added, “If I’m concerned about housing and where I’m going to live, then I’m not concerned about prenatal care.” Another interviewee emphasized the value of a home safety assessment to **minimize the mother and baby’s exposure to environmental toxins**. A third noted that **women may be facing intimate partner violence**, and may need temporary shelter or housing for their own safety.

Others in both rural and urban areas emphasized **transportation as a key barrier to adequate perinatal care** -- when “the hospital I’m supposed to deliver my baby at is three buses away or a \$30 cab

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ride.” In one instance, CHWs worked with a hospital to set up a pre-labor and delivery observation room for patients so these patients weren’t sent home, only to have to start the long expensive transportation process over again in another 12 to 48 hours -- or worse, not to come back because they had no more money for transportation. Some interviewees said that **CHWs could be instrumental in arranging transportation** for pregnant and postpartum women, even if they were not permitted to drive the woman to her appointments.

Interviewees emphasized that many pregnant women they serve face food insecurity – and that a Doula or CHW may help by simply checking in to make sure the woman has eaten or help her obtain food. Interviewees emphasized **the critical role of the CHW in helping the pregnant woman build the skills to take care of herself and her family**. Specifically, the CHWs in one rural program made sure pregnant women had food AND know how to prepare food.

“We find a lot of women in Appalachia and other areas don't know how to cook and did not grow up with someone in their house who cooked,” the interviewee stated. “And so, sometimes a home visit is just being two people in the kitchen talking about parenting and figuring out if this is on the grocery list and what do meals look like for the week and how to do grocery shopping.”

4. CHWS SERVE AS PERINATAL MENTAL HEALTH WORKERS: Since CHWs often see pregnant women in their homes or neighborhoods, and in between clinical visits, while gaining trust and confidence of these women in a way that professionals do not, CHWs can serve as vital front-line perinatal mental health workers. CHWs can be trained in mental health literacy so that they can recognize signs of psychosocial stress, depression, and other mental health issues in pregnant women, and conduct depression screenings. **One expert shared that their CHWs are trained in Mental Health First Aid**, an 8-hour course in mental health literacy often offered for free. [See <https://www.mentalhealthfirstaid.org/about/contact-us/>] Another stated that the CHWs in their program assess the stress level of their clients and specifically the stress related to racial and other discrimination, through administering a perceived stress scale and an everyday discrimination scale.

5. CHWS CAN BE TRAINED IN SUBSTANCE ABUSE/OPIOID EPIDEMIC & INTIMATE PARTNER VIOLENCE: In areas where the opioid epidemic has been concentrated, some **CHWs receive training on substance exposed newborns and the opioid epidemic**. This may be of particular relevance to rural CHWs in Maryland, although interviewees emphasized that training on substance use/abuse in pregnancy can be

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useful for Doulas and all other CHWs. One interviewee stated that the organization's CHWs all receive training in how to recognize and respond to intimate partner violence.

6. CHWS FACILITATE LISTENING TO AND RESPECTING PREGNANT & POSTPARTUM WOMEN: One interviewee stated the CHW or serves as **“extra set of eyes and an extra set of ears”** and ensures that health care providers listen to the woman and take her concerns seriously. While clinicians always need to listen to their patients, our interviewees stressed that clinicians often do not listen to women of lower socioeconomic status in rural areas, or women of color in urban areas, and too often see their cultural expression as a deficit (i.e., view them as uneducated, ignorant of proper health practices, unable to communicate properly). The **CHW can mediate these clinician-patient interactions to ensure that they are respectful and culturally sensitive**. One interviewee described how the Doulas in her program start by making a birth plan with the client, then make all decisions with the client based on her stated birth plan. This is an example of **proactively listening to the client** about her needs and wishes.

7. CHWS PROVIDE OR FACILITATE CHILD CARE: One particular need of high risk pregnant women that our interviewees identified in both rural and urban settings is the ability to bring older children along to perinatal appointments – including therapists' appointments for those with mental health conditions - or to otherwise access child care during these appointments. The **CHW often performs or arranges the child care** during the appointment.

8. CHWS CONTINUE VISITS IN POSTPARTUM. Interviewees stressed the need for prompt and continuing postpartum CHW visits. These visits can involve checking up on immunizations and pediatrician appointments, promote breastfeeding, good infant nutrition, and safe sleep, along with “things as simple as newborn care, how to change a diaper, why it's so important that infants are paid attention to as far as diapers and cleanliness and health.” They can address maternal postpartum complications before they become crises for mother and baby. One interviewee stated that without such follow-up from the CHW, **“women fall through the cracks, because after they deliver, they lose their coverage and then they don't go back to the doctor again until they're pregnant again.”** Several interviewees also shared that in their programs the CHW or Doula visits continue through and least 18 months postpartum, and sometimes up to 3 years.

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9. CHWS EMPOWER WOMEN TO BE EFFECTIVE MOTHERS AND CAN EMPOWER FATHERS. Interviewees emphasized the effective CHW as important in empowering the woman to become an active participant in her health care and her life. one explained that the goal is “for the outreach worker to see what strengths the mom has and help her identify how she's using those to survive and thrive in her current circumstances and help her see how she can continue to build on those **to be the mother that she wants to be.**” CHWs that address father involvement – when funded - can also meet men where they are, whether on the basketball court, in a public setting, or in a men’s group, and can empower them in how to become positively involved in their children’s lives, interviewees stressed. Finally, one interviewee said that most participants like their rural CHW program “because **their outreach worker believed in them...**” It was the first time anybody ever told me I did something good,” one participant stated.

The interviewees also identified 11 urgent needs at an organizational or programmatic level that will have to be addressed in order to more effectively engage CHWs to improve birth outcomes:

1. Increased Capacity, in both urban and rural areas. “Being able to reach all nine counties on the Eastern Shore is a continuous challenge,” one interviewee noted.
2. Sustainability in funding. Eight of ten interviewees identified sustainability as a major struggle for their organizations. “There's no real payment mechanism or structure in the state” for CHWs, one Maryland interviewee stated.
3. Demonstrating their value to the community. “UF we had a young lady who the Resource Mother [CHW] worked with, to take her to doctors’ appointments, make sure she got to WIC, make sure she got her medications, and that she took them properly,” one interviewee explained, “we need to get the health professional to admit that there was a possibility that there is value in having the Resource Mother, and that they made a contribution.”
4. More effective sharing of data. Interviewees stressed that there is a general “lack of information flow” between providers and health systems, and that this information needs to be shared with CHWs and across providers to better track pregnant women - especially those who develop comorbid conditions (risky health conditions) during pregnancy.

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5. More research on what makes prenatal care, home visiting, and CHWs effective in the perinatal period and gestational development.
6. Reimbursement for CHWs from Medicaid and other parts of the health care system, but without limiting the flexibility that CHWs currently have in the different ways they address pregnant women's needs.
7. More training for CHWs in the perinatal period. Rural CHWs in Western Maryland, for example, receive little to no training in this area, according to one interviewee.
8. Better transportation for pregnant women, especially in rural areas. "Riding the bus here, it could take you six or eight hours to get around the county," noted an interviewee from Western Maryland. Another interviewee emphasized that Title 19 transportation - non emergency medical transportation for people with Medicaid benefits, tends to focus on people with chronic diseases, not pregnant women who may have other children and cannot wait long periods for transit.
9. Community-based control over programs, and tailoring of programs to community-specific needs, but under the "umbrella of a state entity": in other words, state oversight but local control.
10. More Telehealth facilities in rural areas for perinatal CHWs.
11. Better pay for CHWs.

III. Detailed description of Findings

A. Examples of CHW-engaged programs: How They work, and What They Do

The interviewees discussed with us specific programs in which they have been involved, how these programs operate, and their scope of practice.

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These programs include:

1. MAHEC (Maryland Area Health Education Center). This is a “community engagement and impact initiative “that focuses on improving Marylanders’ health status “through community educational partnerships that foster a commitment to enhancing healthcare access in the rural and urban underserved areas of the state.” (See <https://www.medschool.umaryland.edu/mahec/>). Note of full disclosure: The investigators are associated with the University of Maryland School of Public Health, which is under the aegis of the University of Maryland College Park, an entirely separate institution from the University of Maryland Medical school, but also a member of the larger 12-university University System of Maryland (USM). We have no direct relationship with the AHEC.)

a. AHEC Eastern Shore. – CHWs make home visits to conduct risk and need assessments. Work to address barriers to care (such as transportation, or day care, etc.). Can also accompany patients to appointments to serve as an “extra set of eyes and an extra set of ears”. Serve as an “informal case manager” for the client, following up to make sure patients attend follow up appointments, fill prescriptions, and are taking medications appropriately. They have been trained to make “health education interventions” such as addressing nutritional deficits, identifying safety issues in the home through an environmental scan, or assisting with breast feeding interventions post-partum. CHWs are trained using MD model - 11 units, 160 hours. Estimates 60 across the state but described a recent cohort of 13 CHWs. Some are full-time, others are part time. Typically identified by the health care systems, often people who’ve been doing this kind of thing for a while, but now formalized. Challenge, not very well paying, \$13 an hour. High retention rates.

b. Central Maryland AHEC – Conduct CHWs training standard 160 hour (120 didactic and 40 hours’ field training) general models but includes one model on maternal and child health. Have trained 177.

c. AHEC West. – employs CHWs trained for standard MD CHW training, but none are focused on perinatal work. They have 4 current CHWs who focus on oral health, addiction recovery, and behavioral health.

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2. Baltimore Community Doula – provides grants to train doulas (they can complete training through DONA international, a certification program - <https://www.dona.org/become-a-doula/birth-doula-certification/>) to work in their own community. “Meet the mother where she’s at.” Develop a birth plan and serve as an advocate. Address basic needs.

3. Baltimore Healthy Start Program: focuses on particular areas of Baltimore with a goal of reducing infant mortality. Hired “neighborhood health advocates” to serve in their own neighborhoods. Recruit pregnant women in their own neighborhoods. Conduct risk assessment at intake and identify needs. Serve as informal care coordinators and link women to care, as well as following up to make sure they’re actually going to appointments. Links to a lot of other programs – belly buddies (group), breastfeeding support, men’s programs, etc.

4. B’More for Healthy Babies: Run by the Baltimore City Health Department. Focuses on community outreach – attending local events to reach families and recruit pregnant women into programming. Relies on “resource parents” to support expectant and new mothers. [Also runs a support group and home visiting program for women who have had a fetal or infant loss – a health department official later informed us. See <http://www.healthybabiesbaltimore.com/our-initiatives/hope-project>]

5. Program in Appalachia & Rural South: Since 1980s, private University (not in Maryland) has partnered with local organizations in several areas to assist with training CHWs (called ‘outreach workers’) to serve local communities. Built on idea of strong relationships. Have programs in urban areas with Hispanic Families and African American families, rural areas with African American families, Appalachian areas with white families, etc. Outreach workers have had little formal education but have “positive parenting experience”. Outreach workers provide “precision home visiting” following from prenatal period, up-to 3 years. Follow a “strengths-based approach” that emphasizes positives. Conversational – not medical. Address needs as they arise, based on MIHOW curricula. Also offer additional group programming.

6. A Community Birthing Center in the Midwest– Partnership between academic research center with a local, for-profit minority-owned birthing center. Not explicitly “CHW” program but does utilize doulas as part of a comprehensive birth plan. Emphasizes culturally sensitive care and community-based approach. Listening to women key. Focuses on culture as an asset, not a deficit.

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7. PEE DEE Healthy Start in South Carolina - rural health care project that serves six rural counties in the state with predominantly African American population. Site was one among the first 15 funded healthy start programs, and one of two funded from rural sites. PEE DEE Healthy Start employs a broad range of programs to reduce IM. Specific program was called ROADS Program (rural outreach, advocacy, and direct services). A team, including nurse practitioner, nurse, social worker, health educator, and outreach worker (aka, "resource mother") went out into the community to recruit pregnant women, get them into care, and follow through.

IV. THE ROLE OF THE CHW: VOICES OF INTERVIEWEES.

This section provides detailed comments by the interviewees on the role of the CHW in perinatal care, organized by subject.

1. Needs assessment/risk assessment

- "The community health worker does a home visit and does an assessment and determines what the individual's needs are based on a lot of the social determinants of health." (AHEC Eastern Shore)
- She would be matched with a resource parent and that resource parent would meet with her to do an intake process and then the mom would identify kind of services that she needs, she feels that she needs around support during her pregnancy (B'More for Healthy Babies).
- The Doulas...take mental health first aid so that they can be able to pick up on the signs of depression and at the far end suicidal thoughts or behavior, and just little things. Making sure they eat, bringing them bottled water, helping them to manage and navigate their appointments. And just like I said, it changes from client to client and point of contact. (Baltimore Community Doulas - BCD).
- We know that picking up problems in the pregnancy early is important and again that can be done by closer surveillance, not necessarily doctor visits but surveillance (Health system executive - HSE).
- They agree upon that plan. She does a series of scales, so we do a perceived stress scale, we do an everyday discrimination scale, we do some additional scales that we're testing (B'More)
- We have an enrollment packet. It's an initial interview. And then it's a participant identification form. There is a depression screening. We start off with an admission with reproductive life

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planning, and emergency resources (BHS)

- But we all do the same intake, which is based on a CMS tool for social determinants. So it kind of helps prioritize the needs. The needs go into the system and that's how-- and whoever puts them in there starts the referrals. With us, with community health workers, they would continue to work with them. They wouldn't just refer them and then move on. They would continue to meet them if the person so chooses. (AHEC West)
- **Preterm birth:**
 - We added to the checklist medical questions so that we could determine if a woman was in pre-term labor and to facilitate her getting care as soon as possible. we added to the social determinants of health medical issues because the bottom line is even though the cause may not be medical, the issue then is medical at the end, infant mortality. (Baltimore Healthy Start - BHS).
 - For example, she has her checklist and the woman says that she's 28 weeks and she says, "I feel my baby balling up," that's one of the questions on the checklist, then she turns to a certain page and then she assesses that, and then she comes back to tell the nurse, me, what she found. And then we get the woman to labor and delivery (BHS).
- **Additional screenings:**
 - **Opiates:** We have done extensive training with our staff on substance exposed newborns and the opiate epidemic (BHS)
 - **Telemedicine:** Now they have, it's amazing all the testing that can be done at home. I'm sure a urine test could be done at home and sent in to a lab. You wouldn't have to go to a hospital to get that done. And so to the extent that we're rapidly entering the age of remote monitoring and telemedicine I think that is going to definitely make things a lot easier and it's going to level the playing field for accessibility. (HSE)
 - **STDs:** she has all of that information and we collect urine at enrollment for chlamydia and gonorrhea testing (BHS)

Birth Plan/ Birthing Support

- One of the first tools that we use is the birth plan and we, depending on at what stage of her pregnancy we make contact with her, let's say if we made contact early in her first trimester, what we do with the birth plan is we go through the birth plan and then we guide all child birth education based on what it is that she envisions for her birth. (BCD)

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- We go over in the birth plan and it's really what that particular mom wants and what other support outside of us that she will have. We do, I guess, the typical Doula stuff. We offer comfort measures to try to keep her focused, to keep her engaged, to help the labor progress as it should. (BCD)

Home Visiting & Postpartum Care

- And then once the baby is born they may help with breastfeeding interventions to help the individual be able to successfully breastfeed if they choose to, they talk about the importance of immunizations for young children, and things as simple as newborn care, how to change a diaper, why it's so important that infants are paid attention to as far as diapers and cleanliness and health, and also the infant's nutritional needs, and making sure that the baby is also getting the after care in terms of their health appointments once they have been born (AHEC Eastern Shore)
- Ninety days and then-- or pretty much the-- I know of one program where a community health worker works for 90 days with the patient through pregnancy and after birth. Meaning they may work with the pregnant mother from seven months through the first month of birth. (Central MD AHEC)
- **Home visits will run monthly from pregnancy through age three.... We have a curriculum, and so each visit is set up with four or five objectives. And the outreach worker prepares for the visit by determining which of those objectives she thinks will best fit the family's needs and desires at that time. So she'll pick two or three of those objectives to plan for the visit. (Appalachian University Program - ApU)**
- And then within 14 days, the case manager makes a home visit. At that particular home visit, a care plan is completed. (BHS)
- We have to do home visits a month. One visit you have to have face to face contact with the client. The other can be a center visit. You can make a telephone call, but one of those visits you have to actually see the client. If there's medical issues, for example if we find that the client has taken 17P for example, then we increase the visits. Maybe we'll go once a week. If the client tells us that her blood pressure was elevated, when we make the visit, we will assess her blood pressure at the particular visit (BHS)
- We try to, usually it's not a face to face contact or even a phone call. It's just sometimes just a

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basic text message just to check in, just to see how you are, or that they know that they can text or call with any concerns. And unlike a traditional doula model, our work doesn't end when a baby is born or a pregnancy has been terminated. We try to keep in contact, set the groundwork to keep in contact with that mom at least until two to three years of age of her youngest child that has come through that we have helped support her birth for (BCD)

- Postpartum we try to check in with her at least 24 hours after she is discharged from the hospital and just to check with her, and then at least a face to face meeting with her up to 48 hours after she is discharged. And once again the biggest focus for us at that point before she goes to her six-week postpartum checkup is to really keep an eye out on those complications that can arise immediately after birth (BCD).
- And at the minimum resource moms are meeting with their clients monthly. If there is a crisis it could be weekly, depending upon what is going on. And then we also make a referral to home visiting services to make sure that families are connected to home visiting, that they know about that opportunity. And basically with that mom until she delivers her baby and her baby is 18 months, although now we're going to start going out to three years, so we're building out that part of the program now...(B'More).

Health education intervention

- And so currently they do a lot of health education interventions, so when it comes to pregnancy they might be addressing like nutritional issues to make sure that the mom is eating correctly, safety issues to make sure that the household is safe and free from toxins. That's why that environmental scan is so important (AHEC Eastern Shore).
- But unless they've gone through a training specific to child and maternal health, then they do not give health information or health education (AHEC Central).

Care coordination/connections with providers and community resources

- They are an informal Case Manager, so to speak, to be following up with them, to make sure they're going to their health appointments, they're getting their medications refilled on time, they're taking their medications appropriately, and so on and so forth (AHEC Eastern Shore).
- But many times those women fall through the cracks, because after they deliver, they lose their coverage and then they don't go back to the doctor again until they're pregnant again. They usually don't see their PCP. And so they sort of just are off in the horizon. So, again that is where

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community health workers can help with that and pediatricians can help with that. (HSE)fextra

- And so they might assess what is the support system that this person has or does not have, and then making sure that that individual understands the resources they have available to them, public programs that they may be eligible for, and so on and so forth (AHEC Eastern Shore).
- Community health workers usually are part of a care coordination team. And their job is to provide resources for the patients. Those assessments are usually done by the social worker when there is a social worker on the team. In smaller clinics and in private practices, there are no social workers. So the community health workers are identifying the needs through needs assessment surveys, and are connecting them with the community resources (AHEC West)
- Care coordination starts to happen. For example, the depression screening is done. If we find that she's depressed, then she's referred to a therapist. Once a referral is made, that referral is data entered. That referral generates a disposition. And so we follow up to make sure that the client kept her appointment. And we remove any barriers to her keeping that appointment, including childcare (BHS).
- I believe that community health workers help in terms of staying in contact with the moms and monitoring their pregnancy closer than they can with doctors' appointments, because that is just not going to work if you're having to go to the doctors. And so to the extent that we can monitor at home and have visits at home I think the experience will be better as well as the outcomes. They will be less, fewer emergencies (HSE).
- The paraprofessionals, their work they are out in the community doing the outreach, they're facilitating the groups, they are identifying pregnant women, they are working with those pregnant women and families and providing nonmedical case management services (B'More).
- Women need, they need help in navigating the healthcare system and coordinating the care between the different places they need to go, and looking for ways to make it more convenient for them. So, now a good navigator would know, "Okay, you have a choice. You can go to see a nutritional expert or there are health coaches online that can follow you. So, they would have that personal relationship with the women to make the best decision according to their preferences and their lifestyle, and it would definitely do her a service, because she needs nutritional counseling and exercise. It doesn't matter if it's virtual or in person or something in-between (HSE).
- And then we're following that mom, identifying and connecting her to resources, coaching her as she is going along (B'More).

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- A piece of our outreach is connecting with our partners, is that they are able to refer the people that they serve through our community health workers because they might have a different reach. Like the hospital has a different reach than maybe the people that we would see at an outreach event versus maybe another nonprofit, community nonprofit that serves a different population. So I think that that-- those professional partnerships are important to our outreach as well. (AHEC West).
- -- But what I think the key here, at least from my perspective, is that the community health workers talk to each other, they communicate with each other and they work closely as a team. So they would help each other with referrals. (AHEC West).

Streamlining Applications and Care Coordination?

- I think there's just a fair amount of value. The partners can see what's really happening with referrals. Are people falling through? So we can help streamline what we're doing, not have multiple intakes of the same arduous nature for people. Not have many, you know, ten times verifying your income. If it's already done here at the Department of Social Services, then it's already done here. (AHEC West)
- If we already know these factors and these factors are part of what makes her eligible for certain services why is it then up to her to have to navigate up to eight different agencies, fill out maybe seven to eight different applications, go to seven to eight appointments, have to wait 30 to 60 days for a decision? It's like this is a no-brainer. (BCD)

Empowering Patients

- **Empowering** community health workers go beyond just the referral and information. They accompany patients to appointments, insure that patients are understanding the information that they're hearing, and finding-- and helping them, empowering them, to speak up and to become active members, active participants in their child's care. I'm sorry, in their healthcare (ACEC Central).
- **Strength-Based Approach** The strength-based approach in general is just this idea of not starting from the idea that a family or a person has a deficit that we're trying to fix, but really starting with the idea that we're going to focus on strengths. And so, in the [Appalachian University] program, we say **regardless of living situation or circumstances, every family has strengths.** (ApU)

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- And so, part of building that relationship from the very beginning is for the outreach worker to see what strengths the mom has and help her identify how she's using those to survive and thrive in her current circumstances and help her see how she can continue to build on those to be the mother that she wants to be. (ApU)
- And so we have a parent leadership group that meets here. And they have this curriculum where they talk about empowerment. They discuss self-esteem and how to maneuver
- And we work on resilience by bringing them out of isolation, by teaching them-- and I call it speaking power to weakness-- by telling them that they don't have to accept being talked down to. They don't have to accept being treated less than. They can demand what they want and expect to get it like anybody else (BHS).
- We don't, we only take a role, I say an advocacy role if that is something that has already been discussed with the mom and her family. We don't offer them advice. What we do is try to give them all of the necessary, all of the information that they will need to be able to make an informed decision, and we support her in whatever decision that is (BCD).

Addressing Barriers

- **Transportation:**
 - Well, if the hospital I'm supposed to deliver my baby at is three buses away or a \$30 cab ride, taxi ride," these community health workers recognize that and are able to provide this information to the hospital. And some of them have actually have a pre-labor and delivery room for patients for more like observation. And this has come out of information that community health workers have been able to share. (AHEC Central).
 - We try to remove whatever barriers she may experience while there. We have a van; we will transport her to her prenatal appointment or her postpartum appointment or her well woman appointment (BHS).
 - Some doulas have driven clients to appointments or have helped them. I know sometimes I have used my Uber account to make sure a client got to an appointment. So, whatever, it's like whatever, however, whatever means we try to make it happen (BCD)
 - Our community, since they're using their own vehicles, we don't have liability coverage for them to transport a consumer. So they can go out to that person's house or meet them at the doctor, but they can't transport anyone from anywhere, from point A to

point B. They don't transport anyone (AHEC West)

- I also think that with doing the home visits and meeting people where they are, I think community health workers really can have a positive impact on the issues of transportation; not only in the rural communities, but in the urban communities, too, because they have their own transportation issues. But I do think that community health workers can help solve the transportation issue. (AHEC West)
- Sometimes maybe accompany them to their appointments or send them reminders, "Okay, you may have, you have an appointment with social services on Tuesday, so don't forget. Call me Sunday if you think you may not have transportation," those types of services. (BCD)

- **Childcare:**

- In some cases, community health workers are accompanying pregnant moms to visits so they can actually watch the children while the mom has the visit because there's no childcare available in many of the clinics, and especially not in the private doctors' offices (AHEC Central).
- The neighborhood health advocate may also go with her to the appointment and watch the child while she's in her appointment. Or, if the appointment is here, then she can bring her baby and we have a childcare center set up with certified childcare providers (BHS)

- **Healthy eating:**

- **We find a lot of women in Appalachia and other areas don't know how to cook and did not grow up with someone in their house who cooked. And so, sometimes a home visit is just being two people in the kitchen talking about parenting and figuring out if this is on the grocery list and what do meals look like for the week and how to do grocery shopping. Just a lot of really kind of life skills kind of things. (ApU)**
- So, if it's something as simple as, "Well, Ms.____, I really just need something to eat tonight" then I try to make that happen for her (BCD).
- Providing resources with transportation, food, making sure that they know how to fill out the applications, that they are filling them out, meeting deadlines, insuring that they're going to their prenatal doctor visit, that they're signing up for WIC. Those types of things (AHEC Central).

- **Addressing 'Crises'**

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- So, that could be a partner who is returning home from being incarcerated and helping her kind of manage that and deal with that adjustment process for herself or her family. It could be that she is out of milk and doesn't have diapers. It could be intimate partner violence, being abused and you need to go somewhere for safety (B'More).
- **Other services:**
 - They've changed the name to South Carolina Thrive. But that's where they have—where they train individuals to take applications for TANF or Medicaid or SNAP. So when they come in, and whenever we see the clients, we can take those applications and assist the individual in working through the system, not to have to go—if they don't have transportation. Because transportation is a huge problem in rural communities here. And so that's to help provide services. So they get training on that, on how to help clients. So if we do home visits, and somebody needs to sign up for Medicaid, we can do it there, rather than have them to try to get back into the town. (PDHS)
 - Another thing that's interesting here, and this is all brand new, is a lot of the service organizations in Allegheny County are adding their programs to this **online resource information website called Aunt Bertha**, and it's national. So they go in and update resources all the time. And if you're part of the back end like we are now, you can use it as a referral source amongst partners. And you can follow individuals all the way through (AHEC West)
 - So the other thing with the facts of-- is insurance, **which we still have some people in the rural areas who are not insured**. We happen to be a catch all organization. We have the contract with the state to be the navigators for Washington, Allegheny and Garrett County. So we have the health insurance navigator here as well and the community health workers work with them, too. (AHEC West)
- **Housing:**
 - We're looking at housing because housing is a really, really big deal here in Baltimore City among the urban population...And so we understand that it is a big contributor to the disparity, whether it's infant mortality, whether it's maternal mortality, whether it's cardiovascular mortality, is the big contributor. So we are working with our CAN to improve housing. We were successful in getting legislation passed that requires landlords to register all parties that they will rent to clients, or to community members

(BHS).

Group Programming:

- **In addition to home visits, each site offers group opportunities for people to come..., we have a weekly group with women who are in recovery. And some of our sites host teen groups at local high schools. And there's an outreach worker that goes into a prison in West Virginia and does some parenting support there (ApU)**
- We have a program that is registered called Belly Buddies. And the neighborhood health advocates are instrumental in making sure that their clients come to the program, and Belly Buddies is a program for women around the same gestational age and is a stress reduction program. They do yoga, scrapbooking, knitting. They have childbirth education and nutritional counseling and cognitive parenting. (BHS)
- We also have a series of group-based activities. So, we offer prenatal support groups, postpartum support groups, parenting, social emotional parenting groups, breastfeeding groups. Many of them are community based. Actually all of those are community based, so they're right in the community (B'more).

Other Programming:

- **Men's Services:**
 - We have men's services. We have always had men's services. As a matter of fact, the Center for Fathers and Urban Families, Joe Jones, started with Healthy Start. So we have always considered men, but this particular grant funding, men are actually going to be part of our client population. And we use a curriculum for men and all of our tools that we use are evidence-based, too (BHS).
 - We had a program once working with males. But it was very loosely structured. Like the male worker would meet with the—Well, the way he recruited them was he went on the basketball courts. Or they went to shoot pool or something. Then he would get them into a session. But they talked about being fathers and so forth PDHS).

What do CHWs add?

Added Capacity to Healthcare system

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- Rural areas where health care provider shortages: CHWs add needed capacity to h.c. system.
- Surveillance beacons: can provide valuable information to communities, states, on health care needs of rural/isolated communities (BHS)
- Number one, there is still a capacity problem with doctors, having the capacity to see them as often. And then the most important thing is it doesn't necessarily improve the quality of care seeing the doctors more often.
- Can ease workload of physicians, especially in rural areas "So, we have some physician champions who have said, "Because I have this community health worker I don't have to make follow up phone calls at 6:00, 7:00, and 8:00 at night after my practice closes down." (AHEC Eastern Shore)
- What the return on their investment would be, and how it really, it reduces costs, emergency room visit costs, so hospital systems are invested and interested because of that factor, it optimizes the patient's health, which takes the burden off of primary care and other providers (AHEC West)
- \$pecially in a medically underserved area, because we don't have enough of anything, we don't have enough primary care physicians, we don't have enough nurse practitioners, physician assistants. And so in order to provide for access of care and reduce patient load we try to explain how a community health worker can take the burden off of a physician, for instance (AHEC Eastern Shore).
- And again if you've got the social worker, the community health worker, the pharmacist, the PCP, and then any other specialist, and they're all communicating then that is going to optimize the health outcomes and it's going to reduce the burden and increase cost savings for everybody (AHEC Eastern Shore).
- To the extent that there is more home monitoring, there is more we are doing ultrasounds at home and you can do lab tests at home, the community health worker definitely will play a part in that in the education, and not only in the education but in the coordination of care (HSE).

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- **Dedicated to Cause/Low Turnover:**

- CHWs have low turnover as they are committed to their communities (AHEC Eastern Shore)
- We don't have a high turnover here. Like I said, most of the folk who are working here were working here since 1994 (BHS)
- (Counter example) But I can say one of the biggest challenges is having a steady stream of Doulas or people who are serving in that capacity. There is a high rate of turnover and burnout. And it's not, and I try to explain to people it's not necessarily the burnout from supporting the clients. It's the burnout from knowing what a client needs and then trying to put that person into those resources (BCD).

Increased Responsiveness

- Timely identification of risky conditions that develop during pregnancy, ensuring adherence to prenatal care, continuity of care (HSE)
- For example, at the state level they would be assigned certain communities in those jurisdictions and they would be the folk who would come back to the community and do town halls about, okay, we found this in this community. We are working on this. What kind of things do you need us to do? What do you see as a need? And then bring that back and then work and have Title V and all the folk who get the maternal child health grants, the chronic disease grant, and all of that, work together to build healthy communities (BHS).

Reduced Costs

- Community health workers through this new community transformation model will be assigned in some cases through some organizations to physicians specifically. However, the hospital or medical center will be absorbing that cost. And community health workers really-- the impetus for the program, at least in Maryland, is to improve health outcomes. But the financial emphasis is to reduce admissions, reduce emergency room visits. And therefore, if there's a cost saving, then I think that cost saving should be funneled back into community health worker, some community health worker payment model. (AHEC Central).

Mothers and Babies from these programs go on to serve their community:

- So that's one of the feel-good moments or feel-good things about our participants and see what

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the results were of the efforts. Because it's not only the birth outcome, but it's those other systemic things that impact a society, where they have gone on and done other things and become contributing members (PDHS).

Know their Community

- CHWs know their communities well/better than outside providers, because they come from the communities they serve (BCD)
- These community health workers are placed in their own neighborhoods, usually. And so they understand the barriers, they understand just the norms that the people who they're serving and working with will experience, whether it's substandard housing, whether it's transportation. (AHEC Central)
- We found that women who live in the communities that they serve understood that community and could relate to the other women living in that community. And most of these women had had their pregnancy and were rearing their children within that community. So they had great knowledge about those women, and they were able to establish great rapport (BHS).
- "Okay, so is the goal to meet the need of the client or is it the goal to get this client and her family to be this mom, dad, and white picket fence?" It is not a reality for some people, and it will never be a reality for some people, whether they choose it or not. I said, "You need to be able to meet the mom and her family where she is" (BCD).
- Our strength primarily is in our ability to partner with community partners and organizations who are doing the work for residents in the community (B'More).
- **Our method is we meet people where they are.** So we don't expect people to take time off of work and try and find a bus pass just to get into our office when we have the capability to go either to their house or meet them at McDonald's or at the library or if they want to take a break from work, we can meet them at their work. So we meet them where they are out in the community. And if a home visit is not a viable option, if it's not safe or something like that, then the library or McDonald's is always another great option (AHEC West)

Liaison/interpreter/translator of medical terminology

- "They may accompany the individual to the doctor's office so that there is an extra set of eyes and an extra set of ears to listen to the diagnoses, help explain in normal layman's terms what the doctor is trying to say" (AHEC Eastern Shore).

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- They have been educated in medical terminology, in the social determinants of health and health literacy, how to improve health literacy for these individuals (AHEC Eastern Shore).
- When things are written in what I call medical-ese or even-- and just language of bureaucracy, our community health workers are helping just to translate that information. (AHEC Central).
- **But she is really going in and having conversation with the mother and finding out how things are going and helping really listening to what the mom pinpoints as her struggles or what is going well. And then figuring out how to help the mom move forward in the direction that she wants to go. (Ap U.)**
- Instances where that patient-clinician relationship breaks down is where we see a lot of discontinuity of care, we see kind of-- not a failure, but the transmission of helpful clinical information kind of breaks down at that point... We're hearing women say is that they don't feel listened to, they don't feel that their blackness is seen as...or they feel like people are making a series of cultural judgments about them within traditional care settings (COMMUNITY BIRTHING CENTER).
- And basically, the community health worker was the liaison between formal and informal healthcare settings. The community health worker was in community health, meaning that-- and this is something that I truly believe-- that health lies within the community and not in the formal systems of care (BHS).
- Because if you have someone in a white coat that's going out and meeting with people and talking to them about diabetes and their mental health, the message is received in a much different way than they would see someone maybe on their level from their community talking about a workshop or a class that they suggest they go to. It's a different message (AHEC West).

Trusted Relationships/Social Support/Cultural Understanding

- Trusting relationship with client leads to more disclosure of perinatal health risks, i.e. prior abortions, than with professional providers (HSE)

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- So, we're sort of the boots on the ground people. And I think the other thing is we're extremely flexible (AHEC Eastern Shore).
- This idea of alliance between the outreach worker and her participant has been really important because, as we look at attrition and compliance for programs and things like that, a lot of it, I think, comes down to the fact that there's not as much of a relationship between the visitor and the person that she's visiting. And that's where, I think, community health workers really have a strength, is that they're good at forming those relationships (Ap U).
- They like the program because their outreach worker believed in them, or somebody said, "It was the first time anybody ever told me I did something good." And some really impactful statements like those really underscore the importance of having that kind of support when you're going through a stressful time like pregnancy and early parenthood (Ap U).
- And a lot of women talk about in previous births at hospitals, not feeling respected or listened to because they're African American or present as African American. And so that's something they report doing really well. And feeling like in that space, they didn't have to explain themselves or kind of be wary of staff having preconceptions about them (COMMUNITY BIRTHING CENTER).
- For things that are as private as pregnancy, in many cultures, people want to talk to folks from their own culture. They want to talk to people who understand the foods that they're going to eat, what their relationships are with their extended families and how that plays into their-- and I will say ability to follow certain guidelines set by their healthcare professional. And community health workers were able to assist them and work with the families to help them understand not only the United States healthcare system, but also even in some cases regulations, rules and new guidelines for infant care such as sleeping on their back, not sleeping in the bed (AHEC Central).
- So, I think that getting those, connecting the dots, coordinating the care, finding out information that is hard to find out about, the healthcare workers are just invaluable in doing that (to learn about past abortions – which may be difficult for others to access (HSE).
- And still need to have knowledge of the community, and still live in the county in which they provide services. We still feel that that's important, because in rural communities, people are more apt to—well our clients are more trusting, or they find it more comfortable to relate to those individuals that they see. And they have to be culturally sensitive (PDHS)

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- And they have to have trust. I mean we stress confidentiality, the importance of confidentiality, because that is a biggie in trust. Because if they—And oftentimes what we've found is that we've found [whenever we were doing our programs when I was at DHEC, with the Robert Wood—with the Rural Care Project early on. A lot of the participants or clients would test their workers. And if they couldn't trust—If they shared something with them, and they felt that they violated their trust, that was a huge, huge problem. And so they are very, very—it's very important that they feel that they can trust the individual at times is working with them. And that's true today.
- Because my other point was, is that a lot of us wouldn't make it if we didn't have someone that we could rely on. We all—I mean that's just a part of human nature (PDHS).

Adaptability/NOT formalized system

- So, it's really, it's not a one size fits all kind of structure, but we let that mom and her family decide how we can best serve them without us being overbearing and forcing something on them that they're not really willing to have for. If they want it it's there, if they don't that's fine also (BCD)
- I think it's a good idea for community health workers to become organized. I don't want them to become organized and become more—I don't want us to get them into such a box that you lose the uniqueness of having the community health workers, that the creativity of being a community health worker is lost. Quite often, and I don't know if I'm saying this right. But we don't want to lose the creative piece of the community health workers and what they have to have by becoming so formal, where you don't recognize. And they just become another pin in the whole structure of things, where they're guided by so many policies or guidelines that you lose the value of what they have to offer (PDHS).

CHW Training

- AHEC recruits CHWs through health depts., FQHCs, hospitals, doctors' offices (AHEC Eastern Shore)
- 11 core competencies, 160 hours including 40 hours of field experience (AHEC Eastern Shore)
- And so there is nothing to say that we couldn't add units on maternal child health and wellbeing,

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but currently right now it's not in there, in answer to your question (AHEC Eastern Shore)

- we have an initial training program, and we have competencies for outreach workers. There are four level of competencies. And so, each worker is required to complete level one before she begins home visits. And so, that comes out to about 40 hours of training in those competencies, as well as going with an experienced home visitor on visits (Ap U).
- They did, Healthy Start paid their tuition because we had money then, and they received college credit, six hours of college credit for the course. One was basic medical intervention and the other was advanced medical intervention. And when we talk about intervention, we're not talking about what nurses do, we're talking about being able to ask questions, understanding when there's an issue. And there's a manual that accompanies the NHA when she goes out on her home visits (BHS).
- The training class itself is usually a three-day intensive training, usually held on the weekend. For DONA I believe once you take your training and pay your membership you have up to two years to complete your certification, and I think DTI is the same. Sophia Consulting I think is, her certification classes she gives you up to a year. For us, we try to, we're trying to get everyone at least halfway through the certification process. Our classes start hopefully in May and our grant is in October, so how we figure, how we calculate it is that during that time period all of those three organizations you have to do at least four to be able to either be present or support four births, so the way that we calculate it by October they will have all of that. And that is the biggest, the biggest challenge that a lot of doulas face is getting those initial births to complete the certification (BCD).
- We try to pair them up with mentors that they can work one on one with, whether it's through the program, who comes through the program or doulas who are already working in the community so that they have, they always will have someone that they can fall back on so that we're just not sending them out there alone and having them fend for themselves (BCD).
- Well, the experience is they need to come from the population they're serving. They have to know the population. The education is the community health worker training which it's going to change because the state's still working on what it deems to be guidelines for certification. But, to date we've been training 160 hours-- the AHEC, the Maryland AHEC training curriculum, is 160 hours and in that includes 40 hours of practicum. (AHEC West)
- And there are a couple of others. So every time there's a training opportunity that we can avail ourselves of, we make sure the community health workers get there. (AHEC West)

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- We talk about the role, the expectations of the role, the importance of confidentiality, the importance of serving as a professional, and insist that you have to have boundaries not to get too involved in what's going on with the client, why you want to help. You don't take ownership. You don't take it to heart. Because a lot of the workers took it home with them, so to speak. (PDHS)
- We did training on—Because in this area, we have a high incidence of neonatal death rates, and infant mortality rates. So we developed a lot of our training around signs and symptoms of premature labor, signs and symptoms of the baby that's warning signs of when you might be—when the woman might be—when the baby might be in distress, or when they need to call the doctor. (PDHS).
- Other training that we do is around intimate partner violence, you know, domestic violence, substance abuse, you know, those kinds of areas. And then we do monthly training. We have them to do monthly training. And then other—other areas that would help to enhance their skill sets
- But another challenge was to make sure that we kept a balance. And what that is, what I mean by that is, oftentimes, because the community health workers were able to—Resource Mothers were able to develop that relationship with the clients, oftentimes they felt that they had the ability to do more than they were trained to do, if that makes any sense. (PDHS).

Recruitment:

- Often identified by the health care systems themselves (AHEC Eastern Shore)
- So, they are folks that are already respected individuals, they're trusted individuals, they're part of the faith community or part of their small town community, and they have likely been doing this work without having the training of being a community health worker, so what that really does is it legitimizes them and gives them a credential or a job title, so that helps us with workforce development as well (AHEC Eastern Shore)
- Positive parenting experience, and that they connect well with others, that they're open-minded. So we're really looking at traits that they bring with them and not at more traditional educational requirements (Ap U).
- So, our resource parents, a few live in the community, others are actively involved in their community, but for the most part they are paraprofessionals who have a passion and interest in improving the health of women and children and families (B'More).

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- Having some skills around either any of those maternal and child health areas or interests. So, we have some that are stronger in dealing with teens and reproductive health services and have delivered those or have supported delivery of those. We have others have been doing community organizing. That is their background. We have others who have done years of early childhood work and daycares and childcare facilities. So, they all have usually a high school diploma and then some of them are trying, are in school and college right now, but others are not, so it just varies (B'More).
- So we see the need to hire people who look like the people that we are serving. So in other words, our target population in this area is African-American. So that's who we're targeting to hire (PDHS).
- 18 years or older. They had to be a parent. They had to have a high school diploma or GED qualified. They had to have a car that was working, driver's license that was working... They had to live in the community in which they serve or live in the county. And they had to have knowledge of services available within the community. And services, not being restricted to agencies, but community organizations, you know, like if there were churches, or there was clothes—a Salvation Army or shelter or something (PDHS).
- The majority are women. But we're looking for males. But it's easier with our—At this point in time, we have all women. But now with the Healthy Start grant that we are in the process of implementing now, we have to have a male focus. So we are recruiting for male involvement coordinator. So that's the work with fathers and fathers to be (PDHS).

Workforce development/Additional Training

- They'll become a medical assistant on top of that or they become a first responder or they may go on to become an LPN. And so we also look at that as a workforce development opportunity for folks (AHEC Eastern Shore)
- All of the neighborhood health advocates at one time were also CNAs. We got them certified as CNAs way back when and a couple of them maintain their license. And they went through a rigorous education in terms of taking manual blood pressures. But now we just use the automatic-- the machines to do that (BHS).
- In this cohort we have five women from the community who want to enter into the field of birth work and they have another five who are already in birth work but want to enhance their

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skillset, meaning maybe they're a doula, but they want to, they're already a doula working in the community, but they want to take, their work needs to be certified as a lactation consultant or they are taking the first steps to become, to apply for midwifery school, things of that nature (BCD).

- And one of our resource parents, because of that training and being involved in our program, she has become a certified lactation counselor and she is also preparing now to become a doula. So, we're always looking for opportunities to strengthen their skillset, based on their interests (B'More).

Needs/challenges:

Needs of pregnant/postpartum women

Postpartum care including

Immediate visits within 48 hours of birth (COMMUNITY BIRTHING CENTER)

Long-term postpartum follow-up care + coverage, especially if have medical risk factor, i.e., gestational diabetes "But many times those women fall through the cracks, because after they deliver they lose their coverage and then they don't go back to the doctor again until they're pregnant again. (HSE).

Care coordination

- They need to be connected to the resources in their community. More than anything, their needs need to be identified, their specific need for successful pregnancies and deliveries need to be identified. And they need to be connected to the resources. Not just connected, but they need someone else to navigate these resources (AHEC Central)
- Care coordination is a good thing, but the bad thing is that once this woman and her family become eligible, have been determined to be eligible for these services that she then has to navigate several different systems to get those services. And my argument is if the criteria is her

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health status, whether or not she has insurance, whether or not there is food scarcity, whether or not there may be an issue with stable housing, that if we already know these factors and these factors are part of what makes her eligible for certain services why is it then up to her to have to navigate up to eight different agencies, fill out maybe seven to eight different applications, go to seven to eight appointments, have to wait 30 to 60 days for a decision? It's like this is a no-brainer. We have already assessed that this person and her family are at risk, so if she is at risk why are we then demanding that she, in order to get these services that she has to take time off from work, take time out of school, find a babysitter, find transportation to often offices that are on the other side of town from where she lives. I mean it's like this is kind of pointless (BCD).

General Barriers/ Needs

- Transportation and nutrition are the top-- are the resources that are most specifically identified by community health workers in rural areas, as well as in urban areas. (AHEC Central).
- "Okay, you can apply for SNAP and TCA online." I said, "But then you're making the assumption that someone who barely has a home, has been assessed for high risk, not necessarily just her health but just her circumstances and situation, so you're expecting her to have a 4G phone that has internet access that she can be able to access this online application." I was like, "You're making a lot of assumptions." And they're basic assumptions, and it's like you can't make those assumptions (BCD).
- **We tend not to turn people away who want to be in the program. But when we run our statistics, we find that most of them turn out to be low income. (Ap U)**

Culturally Competent Care

- African American/African immigrant women's cultural needs [respected, honored]: "freedom to be themselves," have family present, other children – also fathers present, "culturally appropriate, respectful care for all black women." Black women "don't feel listened to... they feel like people are making a series of cultural judgments about them within traditional care settings." Racial identity and culture needs to be perceived as an asset, not a deficit, in care

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provision. (COMMUNITY BIRTHING CENTER)

- “But in this nationally representative survey, you have close to 70 percent of African American respondents reporting that they were interested in having an out of hospital birth but were not able to find a maternity care provider with whom they shared a culturally identity or felt that they’d receive culturally appropriate care” (COMMUNITY BIRTHING CENTER)
- Culture is [an] asset; culture is something that is appropriately welcomed within the clinical space to really enrich the relationship (COMMUNITY BIRTHING CENTER).
- “But something that came up a lot was the freedom to be themselves within the clinical space and what it means to have family present” (COMMUNITY BIRTHING CENTER).
- They need culturally competent community health workers. And, of course, linguistically specific community health workers. (AHEC Central).
- Respect/understanding of culturally- and place-specific intergenerational issues related to housing, family dynamics, etc. (BCD)
- Providers with “cultural humility and introspection” (COMMUNITY BIRTHING CENTER)
“[J]ust because you hand someone a brochure and it’s in Spanish doesn’t mean that the work is over, especially if they’re not responsive to what is being said in the pamphlet” (BCD)

Other unmet needs:

Childcare at clinic for prenatal visits, during labor (COMMUNITY BIRTHING CENTER, AHEC Central)

Transportation (AHEC Central)

Nutrition support

Referrals in rural areas for mental health & recovery services that allow women to have babies with them or be pregnant (Ap U)

Address intergenerational dynamics that may hinder pregnant/postpartum women (BCD, Ap U)

More time with provider on each perinatal visit (B’More)

More Services

- They need services beyond 9-5. (AHEC Central)
- I think the more attention that you give to communities that experience vulnerabilities, the better off that community is. If they can't use it now, they may be able to use it later. They will

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get something out of everything, out of every service and the resource that is poured into it, absolutely. (AHEC Central)

Mental Health

- the gaps that we see are in having somewhere to refer families for mental health, that there just aren't resources for that. And so, that makes it difficult. (ApU)
- I think the networks that I find most important would be around housing and also behavioral health and mental health services, and that not just mental health but trauma informed mental health services would be helpful, I'm sure (B'More)
- I don't know that it could be called a huge barrier here. It would be for behavioral health. (AHEC Western MD)

Substance Abuse

- And for recovery services. So as you know, especially in Appalachia. with the opioid crisis, there are lots of people who are trying to find recovery resources in their community, and there aren't enough resources. And especially for pregnant women and women who want to have their babies with them, there are even less resources if they want to go into a residential program. (ApU)

IPV/Domestic Abuse

- I should also say domestic abuse assistance, because many of these pregnant moms are experiencing domestic abuse in some way during their pregnancy and early in their delivery. (AHEC Central)
- we know that there are women who don't have support and women who are experiencing domestic violence and women who experience postpartum depression who aren't in that low-income category. And so, it'd be great if we had some kind of, at least one home visit afterwards where we can get eyes on the person and see if they're okay (ApU).

Support for Fathers

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- Support for fathers as well – from CHWs, providers (COMMUNITY BIRTHING CENTER, AHEC Central, HSE)
- We've got to figure out how to make that system where the intent is to help fathers understand the importance of being a parent and working with their children, regardless of what the relationship is with the mother (PDHS).

Breastfeeding support

- For example, one of the things that I'd love to see is all of my clients breastfeed, all of them breastfeed. That would help considerably. That would be a barrier to infant mortality. We have a breastfeeding program that we run here, and we named it milkmaids because dads came with the mom to the breastfeeding class (BHS).

Oral Health

- Not enough dental health providers in rural areas. And so like, one of our recommendations is to get the child in as early as possible to see the dentist. And so, we were pushing this one year and some of our sites in rural Appalachia called us and said the dentists, they're overloaded. (ApU)

Family Planning:

- And so asking that question, "Are you on birth control?" and "Do you plan to get pregnant this year?" I think is a great first start, and this should be just part of the intake. Anybody can ask that question, but the physician, if the nurse is doing the intake, whoever is doing the intake that should be asked at least once a year as part of the annual exam (HSE).
- And I think that counseling even during pregnancy and future pregnancies and letting people know that you need to have at least 18 months' in-between pregnancies, that that's just going to be important (HSE).

Parenting Support:

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- For me the biggest challenge is really postpartum, making sure that there is, like here in the city we have this, we have an infants and toddlers program which follows children from birth to two, and then we have this school readiness that follows them, picks the family back up when the child is getting to enter Pre-K or kindergarten at either four or five. Well, then you have this gap between let's say two years of age and three and a half years of age where in the city they kind of lose contact with families after that, because there is no other service, middle service between infants and toddlers and between school readiness (BCD)
- It could just be a regular parenting class, support program where families have the option to come or they have the option not to come, but there is that gap service in-between to address issues, to be able to pick up on behavioral issues of the child, whether or not they have learning, other difficulties in learning, do we see early signs of that at two, at three before they get to the school readiness program (BCD).

Housing:

- We have clients who are couch surfing. They don't have addresses of their own. After 18, we have approximately-- almost 65 percent of our clients who don't have a house where they live, they pay rent or mortgage with their children. They are living with somebody else this week, and maybe next week they may be living someplace else. Or, they may be in a homeless shelter. So this is a big deal. And if they have housing in the city, is it lead-free? Is it safe, okay? Does the child have asthma? Is there carpeting? Are there rodents and bugs? All of those things contribute to the dysfunction (BHS).
- The other part of that, too, is that if I'm concerned about housing and where I'm going to live, then I'm not concerned about prenatal care. I'm not concerned about going back to my postpartum appointment. I'm concerned about where I'm going to lay my head, where my children are going to lay down, and where I'm going to be able to prepare a meal (BHS).
- We have an uptick in SIDS deaths. And the reason that we have an uptick in SIDS deaths, I believe, is because of housing. We give pack and plays to the women. The city gives pack and plays to the women. The other five home visiting programs in the city that are HFA, pack and plays to women (BHS).

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- The real issue is not people who live in public housing. The issue is are we making housing outside of public housing affordable and accessible and up to code and up to par? (BCD)
- Well, I mean I think our biggest thing, and we know because we're in the community it's really the determinants of health, so anything that the community is dealing with is going upstream. If we could provide some of that even for the women that we serve, address housing, right. You always want to do work so that people can be elevated and do better than when they came in the door. (B'More)

Poverty

- Women here in the city that have decent places to live have to pay more than 30 percent of their income to housing. And a lot of our clients only receive temporary cash assistance. Or if they work, they're working for mm wage, which is not a livable wage (BHS).

Organizational Needs

- **Increased Capacity**
 - And so if the program needs anything, we need to be able to reach more people with what we do here, because I think it works (BHS).
 - Need to build greater capacity for CHWs in rural areas, especially along Eastern Shore. "...but certainly building capacity and being able to reach all nine counties on the Eastern Shore is a continuous challenge" (AHEC Eastern Shore)
- **Sustainability in funding**
 - "[A]s a nonprofit we spend a great deal of time just generating funds." (AHEC Eastern Shore)
 - A lot of times, these projects are struggling financially and they're not sustainable because we're asking too much of people and giving too little back in return (COMMUNITY BIRTHING CENTER)
 - The big struggle, as you said, is the sustainability. So, we have got to get legislative support. We have got to really continue to advocate to get these people integrated into the healthcare system and stay there (AHEC Eastern Shore).
 - All of that cost's money. But we were cut 60 percent. Last five-year grant, we had \$1.8

million. This year's grant was \$950,000 to do almost the exact same thing (BHS).

- Often there is no money, so it is, we have been fortunate enough that the core group that we have are willing to serve the community at any capacity they can (BCD).
- In addition to that though, because the work has grown, staff has grown, we also have a variety of other grants that support our work, and some of those are private funders and foundation that we apply. So we are always actively seeking grants and applying for grants to supplement the work that we're doing (B'More).
- In 2014, we did not get funded for our Healthy Start. We lost our funding for our Healthy Start grant. And so we really struggled there for a minute. We had to scale back and really do come up with some innovative and creative ways. We really had to hustle to keep our doors open, because we feared that if we closed, it would be just insurmountable to reopen, given all of the changes in the landscape from the federal government, certainly the state government (PDHS).
- So that's the downfall, is there's no real payment mechanism or structure in the state. So they're grant funded. Currently they're full time employees with AHAC and they're grant funded. (AHEC West)

- **Demonstrating Value to Community**

- A challenge has been getting team members to understand the value added that community health workers or Resource Mothers give. What I mean by that is, if we had a young lady who the Resource Mother worked with, to take her to doctors' appointments, make sure she got to WIC, make sure she got her medications, and that she took them properly, we needed to—we need to get the health professional to admit that there was a possibility that there is value in having the Resource Mother, and that they made a contribution. Now a lot of the clinicians said that they—that you could tell if they made a difference (PDHS)
- Number one, somehow we have to find a way that anybody who employs a community health worker sees the value in allowing them to network during work time, that there's a value in that networking. It comes and goes. We see the value here, but not everybody sees the value at different times. It just depends on the employer, right? (AHEC West)

- **Data Sharing/Access/Flexibility**

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- Better, earlier identification of high-risk pregnant women, women with comorbid conditions that develop during pregnancy, and tracking throughout pregnancy and postpartum (HSE)
 - We discussed having community health workers at the state level who actually would then receive information electronically from-- by looking at a system, a computer system, where all the pregnant women would be in the system. This system then would be able to determine if this woman went to clinic A, B, C or D. (BHS)
 - I think that the communication and the data transfer continues to need to be improved.... I know the, CRISP, the Health Information Exchange, now has gone, they, it's a great start. There is still a lot of problems with it, because the data is not standardized. And I had talked to them before, not recently, if they could add to a field that they report, if they could include pregnancies, notification of pregnancy in their reports, especially if someone is hospitalized because of that, because that is still the earlier the notification the better. So, we're still kind of, all of us are sort of getting it a lot later than we would prefer, especially the high risk, and especially because the high risks are so prevalent (HSE).
 - I think one of the things that causes me the most grief is just the lack of the information flow, the data flow surrounding care just in general. If everything, information, health information is so confined to what health plan you go to or what system you belong to and if you happen to have to leave that system all the information gets lost or there are things that are duplicated (HSE).
 - Better, earlier identification of high-risk pregnant women, women with comorbid conditions that develop during pregnancy, and tracking throughout pregnancy and postpartum (HSE)
- **Evaluation/Fidelity Research**
 - More evaluation/fidelity research on what makes prenatal care effective - "what needs to happen during those prenatal visits" (HSE).
 - And so data, data, data, I think we need to just really make sure that we're concentrating on that, that we're measuring the right thing (HSE).
 - So, it's important that we have data, that the data is granular, that we all are using the same definitions when we're describing conditions or the instances or the use cases so

that we're all on the same page and we're not describing apples and oranges, which is going to skew our data and set us back (HSE)

- We're also doing a little bit of research, so and we've been doing that for the last nine years, and that basically is looking at the risk factors and protective factors for the women who are pregnant, during their pregnancy and upon delivery and every three months thereafter until their babies are 18 months of age, because we want to see if what we're doing is making a difference. So, are we making a difference in reducing smoking habits during pregnancy and thereafter? Are we making a difference around making sure folks are not dealing with food insecurity and housing instability? Are we making a difference around behavioral health? Are we making a difference around breastfeeding? So, we have identified various factors that we're monitoring while the woman is involved in our program (B'More).
- Yeah, and we have not, we have published a couple articles, true, but not like everything that we do, so they have been facets of the work that we do around breastfeeding, around reducing, improving birth spacing. So that is the way we have published, but not the overall project. We've got to find the time to do that though (B'More).

CHW Standardization/ Reimbursement:

- It would look like a **reimbursable program** that pays community health workers to work with pregnant women who are experiencing vulnerability. And it would be any type of vulnerability. Food, housing, transportation insecurity, past domestic abuse, and education, language, culture, any of the challenges that a pregnant woman experiences and think they should be connected to a community health worker who has been specifically trained in child and maternal health and as well as need. (AHEC Central)
- I think that it could, in the state of Maryland, it could be directed through the Maryland Department of Health as part of Medicaid, as part of the Maryland health exchange. It just is part of those programs that are funded with state dollars to include a community health worker reimbursement program. (AHEC Central).
- First of all, in ACA, there is a section of ACA that says that community health workers are eligible for reimbursement if they have a doctor's order to do the work, whatever that work is. But it depends on the state as to whether Medicaid wants to fund that. So most of the states, I guess they-- some states do, some states do, but Maryland isn't one of them (PDHS).

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- Well, to be honest, there really aren't any reimbursement structures for Doulas. I think with the advent of the community health worker certification here in Maryland that may help with access to those who are serving in the capacity as doulas be able to access maybe jobs or reimbursement through Medicaid, because they are community certified by the state (BCD).
- There is a long term goal and the long term goal is to Doulas here in the state of Maryland be reimbursed in Medicaid to make a doula program sustainable enough that they could come through the HCAM system and that that would be included on budgets for programs like the home visiting nurses or other programs like Healthy Start who are using doulas in their programming so that doula and that network of doulas that they have then can be reimbursed for their services (BCD)
- And I guess in terms of insurance, from what I understand, it could be-- some services could be Medicaid billable? I'm not sure exactly. (AHEC West).
- I would start with a certification for training. I think that that would solidify the value in communities. I would create a-- almost like a-- in different pockets of the state right now, they have community health worker, for lack of a better term I use this loosely, association. So there are groups of community health workers. They get together in other areas of the state just to network and share resources and things like that. Along with the certification, I would almost create a big community health worker association. They could share resources, they could network, they could have CEs to continue learning and link all of the community health workers together in that way (AHEC West)

Standardization of training:

- So my perspective is I'm glad there's certification. My concern would be-- the only concern I would have would be if those who were doing it now were somehow excluded. So I don't think that's the route, but we don't really know yet. I'm understanding the parallel universe, so I'd be happy for anyone who's already a community health worker to keep that whether they have education or not. I think it's really important. I think their role should be valued. (AHEC West)
- I think that when the state comes through with that certification, it will be really important for some of the other providers in our community to see that certification come through because right now, we know that there is a huge value in having community health workers out in the community and for providers to employ community health workers. **But I think that that**

certification piece will just help with that sharing the value. I think it will help solidify the value of community health workers (AHEC West)

- Actually just when I read the email yesterday, is we need to include more training related to pregnancy and perinatal. Really, I don't think there's anything in our training, is there? Maybe there is. (AHEC West)

Specific Programming-related Community Needs

- Transportation Assistance
 - I believe, on the Eastern Shore is a large geographic area, very diverse geographic areas. There are different needs in almost every single county that it's locally based challenges. So, for instance, in Caroline and Kent it might be transportation, but certainly building capacity and being able to reach all nine counties on the Eastern Shore is a continuous challenge (AHEC Eastern Shore)
 - Unfortunately, the stipend that many, that the doulas do, like under this cohort they will get a, they will get scholarships as well as a stipend for each birth that they support. Things like Uber accounts, unless they have already established their own business entity that comes right out of their pocket and it's often not reimbursed, because we don't have the means to reimburse for everything that one of our doulas (BCD).
 - Transportation targeted to pregnant women— in rural areas cannot afford auto insurance to enable CHWs to directly provide transportation (Stewart) The expense of it, it's kind of a new world. I'm not sure people really want to drive other people, and you know, we're pretty small and we've never been much of a direct service provider until the last couple of years, so we're still getting our sea legs in the public facing world. We've always been behind the scenes. (AHEC West)
 - The biggest barrier that we hear from the people we serve is transportation. It is a huge barrier out here. And in rural communities everywhere, people have trouble getting to their doctors' appointments, to their primary care. And there are some options. Medicaid has a van that, or a bus, that can take people to their appointments except they're different programs and they serve different-- for different providers (AHEC West)
 - What are the greatest? What are they really missing? I mean, we hear transportation all the time, but we're trying to drill down to the point where we can find a solution

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between trying to find money to put to a real solution. Riding the bus here, it could take you six or eight hours to get around the county. It's the different routes. What am I trying to say? It's just not like an urban area where they're just coming and going from different points. There's a circle that goes around the county and just drops them off and then it just keeps going around. (AHEC West)

- They also just the cost of transportation, car ownership and gas and there's lot of people with cars that either they're breaking down or it's just hard to have the money to fill it up and take care of it. (AHEC West)
- All the transportation, the Title 19 transportation system, most of those systems are designed around kidney dialysis or some other chronic medical disease. And so a pregnant woman, if she has an appointment to get a test done, she might have to leave home five o'clock in the morning, or six o'clock in the morning, because if there is a dialysis patient, because they have to come to the dialysis center to get their—to be dialyzed and so forth. So it's not—And if you're a pregnant woman, and you have, you know, small children, or if you just are further along, who wants to—you know. It's just not a good fit to do that (PDHS).

Recommendations

“So, we have got to get legislative support. We have got to really continue to advocate to get [CHWs] integrated into the healthcare system and stay there.” (AHEC Eastern Shore)

Board for CHWs similar to the Maryland Board of Nursing or Board of Pharmacy to manage certified CHWs (AHEC Eastern Shore)

Community-based control over program specifics, based on community needs, under umbrella of state entity: Actual service and organization of service should be done on community, not state level to better meet specific, varying community needs. (BCD)

Integration of life course approach to health care and prevention for all women— not just care during perinatal period (BCD)

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Providing health during a woman's lifespan, and the reason they were concentrating on the woman is because she is usually the head of the house, not only does she make decisions for herself but she is usually the one who makes decisions for her family as well as her parents. I mean she has a very pivotal role in terms of health, not only for herself but for the people around her (HSE).

Coordinating entity run through the state but in collaboration with MCOs, hospitals, health depts., community orgs. to coordinate care, CHWs, for high-risk pregnant women (AHEC West)

Make perinatal care more community based - "[W]hen I say community based I mean in the community, and having midwives who are trained and doulas who are trained of color to support women." (B'More)

Additional training for CHWs in Maryland in MCH – Could be implemented by AHECs (AHEC Eastern Shore) . Central MD AHEC already provides a module on MCH in CHW training (AHEC Central) but it could be expanded.

Specific training in the gestational development, and I think that's what's missing...Maternal childcare, yes. Training specific to that there are-- like I said, there are training tools for diabetes, specific to diabetes. There are training tools for hypertension. But most of the training tools for maternal and child health are geared towards clinicians (AHEC Central)

Need a MORE DIVERSE OBSTETRIC WORKFORCE "It shouldn't be a rarity or a huge surprise for someone to see a provider to walk in the room who looks like them, or shares-- or maybe grew up in the same neighborhood as them." (COMMUNITY BIRTHING CENTER)

Telehealth: Just the ability to send them information, like some patients, information electronically. Just the ability to connect on a regular basis with someone by telephone or teleconferencing (AHEC Central)

Better pay for CHWs (AHEC Eastern Shore)

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We have all of the tools available right now today, as I sit and speak with you, to do that. It is a matter of the will. And when in talking about the community health worker at the state, you know, doing this-- it's like the umbrella, as you mentioned, spanning out to help and making sure that we are all connected. Even if we are divided by borders, that we are connected one to the other and that in our hearts, we really want to make a difference. And so I just think that institution building, and I think that collective thought is where we need to be (BHS).

So, those type of things it's just like to get people to understand those basic things, that things do need to be centralized, things do need to be streamlined, agencies must learn how to work together. We have-- She goes through HCAM, she gets her risk assessment. Why does she have to make a separate appointment to apply for SNAP and TCA? We already know, okay she is pregnant, she may be unemployed or underemployed, so why not just make it easy? (BCD).

Care coordination should be left up to that jurisdiction and that care coordination should be flexible, and that it's just not solely rooted on one aspect of maternal care but just from just family support period (BCD).

So, legislative I would establish, and financially I would, and policy-wise I would establish medical homes for pregnant women that would coordinate their care, ensure continuity of care, and not just during, it would concentrate on during the pregnancy period, but there would have to be a lifespan component to it (HSE)

And another piece that we are adding onto our Healthy Start program this time is the maternal mortality piece (PDHS)

I just was at a meeting, local health improvement coalition meeting, and one of the nurses came in and gave a presentation of the substance affected newborns and what's happening over the years. It's just really skyrocketed, it's kind of bounced around staying high for several years and so it's pretty alarming. And we know, we are involved in the opioid issues here. We are one of the hardest hit parts of Maryland

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and Appalachia, for that matter. The Baltimore City, Allegheny County, Washington County, pretty much-- we're kind of the epicenter of it all. So I'm really glad we had this talk. (AHEC West)

Needs assessment: : So the first thing I would do would be like an assessment with the provider partners, like the FQHCs, the health department, talk. We communicate around here so I would see what they thought the need was. And if it was needed and we could do it, it would take the money for the full amount of salary for an individual and some training time, really (AHEC West)

It would be a comprehensive approach, because you need your medical providers, but you also need that support. The support goes beyond just having a doctor or a nurse midwife or a nurse practitioner provide the services, because you have to do—you have to have a multidisciplinary approach. You need your social workers, your nutritionists, your education, your health educators, all of those persons to contribute. And you need to have the ability to have someone that's going to do—And even though I love those professions dearly, some of them are not going out either. To see those clients. But she's one who's willing to start where the client is. And that means to work with them to help them navigate the system, to get what they need to do. And because one of the big instances—and I know you've read about the whole stress, the social determinants of health, how stress is a big factor. And then I would design a transportation system for maternal and child health recipients. We don't have a transportation system here in South Carolina, I dare say. We don't have a public transportation system (PDHS).